Services for Students with Disabilities
Garrett-Evangelical Theological Seminary
CONFIDENTIAL
Pre-Admission Form

Today's Date: _____/_____/_____

Name: _____ **Garrett ID #:** _____
(Last) (First)

Email Address: _____

Permanent Address: _____
(Street) (City) (State) (ZIP)

Home Phone #: _____ **Cell Phone #:** _____

Birth Date: _____/_____/_____

Housing:

____ On-Campus Housing ____ Commuter/Off-Campus

Academic Profile: Major: _____ Minor (if applicable): _____

Degree: ____ MDiv ____ Liturgical Studies ____ ???
____ MTS ____ PhD ____ ???
____ Theological Studies ____ Course of Study ____ ???

Classification:

____ Prospective student
____ Full-time student
____ Part-time student
____ Master's
____ PhD
____ Other (please explain) _____

Date of Enrollment at Garrett-Evangelical: _____ /_____

Transfer student: ___ Yes ___ No - If yes, name of previous institution: _____

U.S. Veteran: ___ Yes ___ No - If yes, dates of service: From _____ to _____

International Student: ___ Yes ___ No

Diagnostic Information:

What is the diagnostic category for which you are requesting accommodations? Please check all that apply.

____ Hearing Disability ____ Physical Disability ____ Medical Disability
____ Learning Disability ____ Visual Disability ____ Psychological Disability
____ Speech Disability ____ ADD/ADHD ____ Other (please explain)

How does your current diagnosis impact your academic work?

_____

_____

How does your current diagnosis impact your living environment?

_____

_____

What is the diagnosis for which you are seeking accommodations?

_____

_____

Accommodation Request Information:

_____ Academic Accommodations **_____ Housing Accommodations**

Please describe the Academic and/or Housing accommodation(s) that you are requesting:

_____

_____

_____

_____ Dietary Accommodations (please circle one):

Dining Hall Accommodations *Meal Plan Change* *Meal Plan Exemption/Release*

Accommodation History:

Please list any accommodation(s) used in high school:

_____

_____

Please list any accommodation(s) used at previous universities:

_____

_____

Please note any additional information that may assist Office of Student life in providing you with accommodations: Use additional sheets if necessary.

_____

_____

Services for Students with Disabilities
Garrett-Evangelical Theological Seminary
Disability Verification for Students with Attention-Deficit/Hyperactivity Disorder

Student Information

Last Name _____ **First** _____ **MI** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Date of Birth ____/____/_____ **Phone** _____

Professional

Date of Initial Contact with Student ____/_____/_____

Date of Last Contact with Student _____/_____/_____

Date of Completion of Form ___/____/_____

Diagnostic Information

Date of Diagnosis: _____/_____/_____

Please list the DSM-IV diagnostic criteria that were identified as present in this case **and** the diagnostic procedures/assessments/scales used to identify these criteria.

_____

_____

_____

_____

_____

Age at onset of symptoms: _____

Please describe the settings in which these symptoms have been most evident.

_____

_____

_____

_____

_____

Please discuss how the possibility of other psychiatric or medical disorders which may cause problems with inattention are considered, evaluated, and documented in the differential diagnosis process. Please also discuss any dual diagnoses and alternative or coexisting conditions.

Treatment Information

Medications

Current medication(s) including dosage, effectiveness and side effects

Current compliance with medication plan

Educational and Behavioral Interventions

Please describe academic interventions, coaching support or other behavioral programs that have been made available and their level of effectiveness

Impact of Condition on Educational Success

Please identify the specific academic abilities or functions that are compromised by the disorder. Indicate severity of these limitations

Suggested Accommodations

NOTE: *Final determination of appropriate accommodations will be determined by Office of Student Life in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws. Each recommended accommodation must be accompanied by an explanation of its relevance to the diagnosed disability.*

Extended time for exams _____ Yes _____ No
Why?_____

_____

_____

_____

Quiet room in which to take exams _____ Yes _____ No
Why?_____

_____

_____

_____

Other accommodations (Please specify) _____ Yes _____ No
Why?_____

_____

_____

_____

Certifying Authority

SIGNATURE: _____ **Date:** _____

PRINT NAME AND TITLE: _____

License/Certification Number and Issuing State _____

Address: _____

Phone Number: (_____)-_____-_____ **FAX Number:** (_____)-_____-_____

Return this information to:
Garrett-Evangelical Theological Seminary
Office of Student Life
2121 Sheridan Road – Room 306
Evanston, IL 60201
Phone:1- 847-866-3948 / **Fax** 1-847-866-3906

The information you provide will not become part of the student's academic records, but it will be kept in the student's file at Office of Student Life, where it will be held strictly confidential. This form may be released to the student with his/her signed request.

Services for Students with Disabilities
Garrett-Evangelical Theological Seminary
Disability Verification for Students with Psychological Disabilities

Student Information

Last Name _____ **First** _____ **MI** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Date of Birth ____/____/_____ **Phone** _____

Professional

Date of Initial Contact with Student ____/_____/_____

Date of Last Contact with Student _____/_____/_____

DSM IV Diagnosis _____

Pertinent History:

_____

_____

_____

_____

_____

Onset of current diagnosed disability:

_____

_____

_____

_____

Summary of present symptoms:

_____

_____

_____

_____

_____

Assessment procedures and evaluation instruments used:

Prognosis:

Is the disability currently stabilized: _____?
Please describe

Medication/Treatment Information

Describe current medication needs and side effects and how the medication will affect the student's educational performance:

How long has the student been taking this medication?

Is the student still adjusting to _____ or stabilized on the medication _____?

Information Supporting Accommodation Requests

Describe the student's functional limitations in an educational setting:

Are there crisis episodes associated with the disability?

Have you any recommendations to make regarding effective academic accommodations to equalize this student's educational opportunities at the post-secondary level?
(Describe services/accommodations in exam administration, classroom or study activities, or course requirements).

Certifying Authority

SIGNATURE: _____Date: _____

PRINT NAME: _____

TITLE: _____

License/Certification Number and Issuing State _____

Address: _____

Phone Number: (_____)-_____-_____

FAX Number: (_____)-_____-_____

Return this information to:

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Services for Students with Disabilities
Garrett-Evangelical Theological Seminary
Disability Verification for Students with Medical Disabilities

Student Information

Last Name_____ **First**_____ **MI**_____

Address_____

City_____ **State**_____ **Zip Code** _____

Date of Birth _____/_____/_____ **Phone** _____

Professional

Date of Initial Contact with Student _____/_____/_____

Date of Last Contact with Student _____/_____/_____

To ensure the provision of reasonable and appropriate services for students with medical disabilities, the Office of Students Life requires students to provide current and comprehensive documentation of their disability and its impact on their education. To standardize the gathering of such information, we ask that the student's healthcare provider answer the following questions.

1. Please describe the student's impairment giving a specific diagnosis and include the date of diagnosis.

_____
_____
_____
_____

2. What is the expected duration of the disorder?

_____
_____

3. If the student is currently undergoing medical treatment, please describe and indicate how the treatment might affect the student academically.

_____
_____
_____

4. Describe how this medical condition may result in specific functional limitations in an academic setting (i.e., problems sitting for long periods of time, unable to type for more than ten minutes, or unable to walk more than 50 feet without fatigue)?

_____
_____
_____

5. List current medications(s), impact, and adverse side effects. Is the student still adjusting to or stabilized on these medications?

_____

_____

_____

6. Please provide your specific recommendations (based upon your assessment, the student's clinical and academic history, and diagnosis) for accommodations that you believe will help equalize the student's ability to access Garrett-Evangelical's educational program.

_____

_____

_____

_____

7. Please provide any additional information you feel will be useful in determining the nature and severity of this student's disability and any additional recommendations that may assist Office of Student Life in determining appropriate accommodations and intervention. Attach copies of other relevant information as needed.

_____

_____

_____

_____

HEALTHCARE PROVIDER INFORMATION

Provider Signature: _____ Date: _____

Provider Name (Print): _____

Title: _____

Address: _____

Phone Number: (_____)-_____-_____

FAX Number: (_____)-_____-_____

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